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**Adult Care Planning Policy**

**[Date of Issue]**

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| --- | --- |
| Policy Lead: | [Policy Lead] |
| Version No. | 1 |
| Date of Issue: | [Date of Issue] |
| Date for Review: | [Date of Review] |

CONTENTS

[1. Introduction 3](#_Toc147935364)

[2. Policy Statement 3](#_Toc147935365)

[3. Scope 3](#_Toc147935366)

[4. Procedures 4](#_Toc147935367)

[5. Expected Outcomes of Initial Needs Assessments 5](#_Toc147935368)

[6. Care Plan Implementation 6](#_Toc147935369)

[7. Revising the Care Plan 7](#_Toc147935370)

[8. Advance Decision to Refuse Treatment 7](#_Toc147935371)

[9. Advance Care Planning 7](#_Toc147935372)

[10. Education and Training 8](#_Toc147935373)

[11. Consent and Confidentiality 8](#_Toc147935374)

[12. Monitoring 9](#_Toc147935375)

[13. Related Policies 9](#_Toc147935376)

[14. Legislation and Guidance 9](#_Toc147935377)

[15. Summary of Review 10](#_Toc147935378)

[16. Appendix 1: Initial Needs Assessment 11](#_Toc147935379)

[17. Appendix 2: Care Plan 21](#_Toc147935380)

# Introduction

All clients entering domiciliary care within their respective communities should be entitled to a personalised individual care plan. The plan should be based on a thorough holistic assessment of the individual’s needs and preferences (both clinical and domestic), as well as their abilities and aspirations.

Care plans for clients should, wherever possible, be developed in partnership with the client, include communication with the family or next of kin, and with the necessary professionals where this is applicable.

# Policy Statement

This policy describes how care planning should be organised at [Company Name], as well as how it should be implemented to achieve its objectives for all clients.

Care plans should always relate to the appropriate clinical guidelines produced by relevant professional bodies in line with the Care Quality Commission’s (CQC) regulation 9, which refers to person centred care. More detailed guidance can be found at: <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-9-person-centred-care#guidance>. Care plans should include also objectives for care, the strategies required to meet those objectives and statements of responsibility for staff (and others), including appropriate timescales of implementation and review.

It is also vital that staff provide optimum levels of dignity and empowerment for clients at all levels of care, while allowing them to remain as independent as possible.

# Scope

This policy and the procedures apply to all staff working at or with [Company Name] and who are involved in the developing of care plans.

The policy is an important part of the overall risk management approach to caring for people in their homes.

# Procedures

A person-centred holistic assessment should be undertaken for each person entering the care of [Company Name] **[DELETE AS APPROPRIATE]** in electronic/in written format (refer to Appendix 1, if using a written format).

**[DELETE THE FOLLOWING PARAGRAPH IF YOU DO NOT USE ELECTRONIC ASSESSMENTS OR CARE PLANS]:**

[Company Name] uses electronic systems and devices to devise and create **clients’** assessments and care plans. The provider which [Company Name]uses is called **[Provider name]** and their contact number is **XXXXX** should any implications arise. Electronic records are kept and maintained as per written records in line with GDPR and confidentiality guidance as outlined in the Information Governance and Confidentiality Policies and Procedures.

This assessment should include the needs of the client on both “good days”, when they are feeling well, and “not so good days”, when they may require more support. In addition to understanding the needs and/or difficulties of the individual, the following must be considered in the assessment:

* **Mental health** – including medication and any additional care that may be required. Staff should pay particular attention to the Mental Health Act 2005 section 117, which lays out the provision of aftercare and follow-up arrangements for clients who have been detained under the Mental Health Act 2005. More detailed guidance can be found at: <https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/>
* **Advanced future decisions** – such as advanced decisions and advanced care plans. Staff should pay particular attention upon assessment to see if a client has such documents in place and where these are kept.
* **Physical** – paying close attention to how the client can move around their home and access the necessary domestic utilities to promote independence wherever possible.
* **Medication** – including what support the client requires to take their medication, in what form i.e., dosette box, paying particular attention to any allergies.
* **Nutrition and hydration** – paying attention to whether the client will need support to prepare meals, drinks and/or snacks and whether the client has any allergies/intolerances.
* **Social care** – including employment, living arrangements and finances.
* **Other** – such as religious or cultural beliefs.

Assessments should be an ongoing process throughout the time that a client makes use of [Company Name]’s services.

Wherever possible, and subject to client’s consent, family and/or their next of kin should also be involved in the assessment and care planning process. The assessment and care planning process are recorded [**DELETE AS APPROPRIATE**] in electronic/in written format. The assessment should consider the current as well as the future affect care might have on the family, especially if children are involved or could be at potential risk.

[Company Name] will make sure the necessary arrangements are in place to ensure that safeguarding risks are identified and responded to appropriately. (Please refer to our Safeguarding Adults and Children Policies and Procedures for further guidance).

All risks and their associated management should be recorded in the client’s electronic version/written version of their care plan (refer to Appendix 2, if using a written format).

Following the conclusion of an assessment, clients, and their family and/or carers, will receive a written copy of the care plan. **[DELETE IF APPROPRIATE]** Should [Company Name], use electronic devices to devise and develop care plans, any updated versions will be provided to clients and with consent, to their family and/or carers. A copy of the care plan will also be shared with any other agencies or healthcare professionals involved in its development, if the client has given their consent to share such information with other agencies or healthcare professionals (please see the Consent and Confidentiality section below).

All clients have the right to appropriate and timely information about the treatment and care options available to them, including the risks and benefits, in order to allow for decision-making to be shared.

Staff at [Company Name] should make every effort to ensure that clients are supported in making informed choices and support the aspirations, goals and priorities of each client, rather than providing a ‘one size fits all’ service. All shared decision-making should be accurately documented in the client’s records.

# Expected Outcomes of Initial Needs Assessments

For each of the expected outcomes identified in the initial needs assessment, [Company Name] will develop a range of strategies in collaboration with the client to ensure the outcomes are effectively met. [Company Name] will ensure the continuity of care, where practicable, by using the same staff for a particular client. To achieve this, [Company Name] will develop a transparent process for matching staff to clients by considering the clients support needs, the staff’s skills and where possible and appropriate, both the staff and clients’ interests and preferences.

Support for clients should focus on what people can or would like to do in order to maximise their independence, and not solely focus on what the person is unable to do. [Company Name] will recognise that clients have continued preferences, aspirations and potential throughout life and that clients with cognitive impairment and living alone, may be at higher risk of having unmet social care related quality of life needs or worse psychological outcomes (National Institute for Health and Care Excellence). This information will be documented in the main body of the care plan.

[Company Name] should offer their clients and carers and/or family, information regarding local and national support groups, networks and activity groups. [Company Name] must also provide enough information about their service in a format that the client and/or carer/family can understand, such as large print or braille documents, to ensure that clients and their carers and/or family, can make informed choices about their care, including but not limited to:

* What to expect from the domiciliary care service and provider;
* Their rights;
* What they should do if they are not satisfied with the service that they are receiving (Please refer to [Company Name]’s Complaints Policy).

# Care Plan Implementation

Care plans should be devised based on the initial needs assessment **[DELETE IF USING ELECTRONIC RECORDS]** - (see Appendix 1) and should identify the expected outcomes that the client and [Company Name] will jointly agree to.

When assessing and implementing the care plan, staff at [Company Name] should ensure that it considers any other existing plans and/or tools that the client might be making use of (e.g., Advanced Directives, Recovery plans, Staying Well plans or Social Care plans). All associated documentation should be referenced in the care plan (e.g., Food and Fluid charts).

The care plans should be readily available to staff, as well as the client and their families and/or carers, where consent is provided. The plan should be regularly reviewed by staff and/or the Registered Manager to ensure it remains on track and in line with the assessed needs and the expected outcomes.

[Company Name] will ensure there are regular auditing processes in place for its care planning documentation. Any other local audit and review arrangements should be developed and agreed upon, within any relevant clinical divisions.

# Revising the Care Plan

[Company Name] will have a flexible approach to reviewing care plans, while at the same time ensuring it remains periodic. Reviews will be performed by contacting all the relevant staff and other professionals involved in the client’s care to ensure there is effective feedback on how care is progressing. The documentation will then be reviewed by the individual responsible for updating the clients care plan.

Depending on the nature of the client’s care, reviews can be done as part of a multidisciplinary approach or a one-to-one basis.

[Company Name] will ensure that all care and support provided to clients is reviewed on an ongoing basis, as required, but at a minimum of every month. Care plans should generally be reviewed when:

* there are significant changes to the client’s condition
* there is a change in the person responsible for/overseeing the client’s care
* there is a specific and reasonable request for a review by the client, their family and/or carer.

Following any review of care, all client records must be updated to reflect any changes that have been put in place.

# Advance Decision to Refuse Treatment

An Advance Decision to Refuse Treatment (ADRT) is often known as an Advance Directive. An Advance Directive is a written document where a client specifically chooses to refuse treatment if they are unable to communicate with their carers’ and/or healthcare professionals.

All Advance Directives are legal documents and must be in writing and signed by the client and a witness.

Staff at [Company Name] will ensure that they are aware of any Advance Directives a client has in place and will follow these directives where appropriate/necessary and/or where it applies to the situation.

# Advance Care Planning

Advance Care Planning allows individuals to plan their future care and support, inclusive of medical treatment, while they have the capacity to do so (National Institute for Health and Care Excellence). Not all people wish to make advance care plans, but they are particularly relevant to those who:

* Are at risk of losing capacity through progressive illness.
* For people whose mental capacity can be variable, i.e., mental health or frequent infections.

Should clients express a wish to make an advance care plan, [Company Name] will arrange, to ensure that the appropriate professional can, in collaboration with, staff, carers from [Company Name] and/or family with consent of the client, visit to discuss and complete an advanced care plan.

# Education and Training

[Company Name] will ensure that there is a training program in place for relevant staff in accordance with the predetermined assessment(s). Any individual training and development needs should be supported through supervision/1:1’s and/or [Company Name]’s appraisal process.

The Registered Manager and/or Director(s) at [Company Name] will be responsible for ensuring the quality of its staff and should regularly review the skills of individuals and their abilities in line with this policy. [Company Name] will ensure it supports its managers in their responsibilities through effective supervision and practice development processes.

# Consent and Confidentiality

As with any client interaction, it is essential to inform them before undertaking any procedure and obtain their consent. If the client is unable to provide consent and a decision is made in their best interests, this should be guided by the Mental Capacity Act 2005 and clearly documented in the client’s records (please see [Company Name]’s Consent, Confidentiality and Information Governance Policies for further information).

All staff working at or on behalf of [Company Name] are subject to the common law of confidentiality. This is particularly relevant when health and social care agencies may need to share information.

Clients should have the right to understand their rights to confidentiality, as well as the confidentiality of their health records.

# Monitoring

The Registered Manager and The Senior Management Team will monitor compliance with this policy through routine auditing. Any client or staff complaints or feedback, as well as incident reporting, will also be used to inform the effectiveness of this policy.

# Related Policies

* Complaints Policy
* Consent Policy
* Confidentiality Policy
* Information Governance Policy
* Safeguarding Adults Policy
* Safeguarding Children Policy

# Legislation and Guidance

**Relevant Legislation**

* The Mental Capacity Act (2005)

**Relevant Guidance**

* Care Quality Commission (CQC) Regulation 9: Person-centred care:
* <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-9-person-centred-care#guidance>
* Health and Safety Executive
* MIND Leaving Hospital (Section 117 of the Mental Health Act – Aftercare)
* <https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/>
* National Institute for Health and Care Excellence (NICE)
* <https://www.nice.org.uk/guidance/ng21>
* National institute for Health and Care Excellence (NICE) Advance Care Planning:
* <https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/advance-care-planning>

# Summary of Review

|  |  |
| --- | --- |
| Version | 1 |
| Last amended | [Date of Issue] |
| Reason for Review |  |
| Were changes made? |  |
| Summary of changes |  |
| Target audience | Care staff, Managers |
| Next Review Date | [Date of Review] |

# Appendix 1: Initial Needs Assessment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Client’s Name | | Preferred Name | | | Date of Birth | | |
| Reason for Referral | | | Information taken from:   * Client * Clients documentation * Family member or Carer (state name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other state\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Place assessment carried out (e.g., client’s Home or Hospital) | | |
| Clients Home Address | | | Next of Kin  Name  Telephone Number  Relationship to client | | | | |
| GP Name  Address  Contact Number | | | Next of Kin Home Address | | | | |
| Emergency Contact (1)  Name  Telephone Number  Relationship to the client | | | Emergency Contact (2)  Name  Telephone Number  Relationship to the client | | | | |
| Named Key Worker | | | Allergies (Do not leave blank) | | | | |
| Advocate (IMCA)/Lasting Power of Attorney/Solicitor name and contact details if involved | | | Funding  (Private, pay full/part/top up. Local Authority Funding) | | | | |
| Social Services Team/District Nurse/Worker Name and Contact Details | | | Any previous safeguarding referrals or current concerns? | | | | |
| Emergency Health Care Plan or Advance Care Plan/Directive in Place  Yes  No  (If Yes please attach copy) | | | Valid Do Not Attempt Resuscitation/ReSPECT Document in place  Yes  No  (If Yes please attach copy) | | | | |
| Detail of other care package currently in place (if previously using a domiciliary care service) | | | Detail informal arrangements provided by family/friends or paid help (e.g., chiropodist) that will continue (ensure that this is agreed by all involved) | | | | |
| Medical History | | | Current Prescribed Medication | | | | |
| Communication Needs Assessment | | | | | | Yes | No |
| Do you have any issues with eyesight, speech, hearing or written communication? | | | | | |  |  |
| Do you require any specialist equipment or person to help you to communicate (such as glasses, hearing aids, interpreter)? | | | | | |  |  |
| Any support required with optician or hearing aid clinic appointments? | | | | | |  |  |
| Do your communication needs change day to day? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Nutrition and Hydration Needs Assessment | | | | | | Yes | No |
| Do you require any support with eating food? | | | | | |  |  |
| Do you require any specialist equipment to help you to eat/drink (such as plate guard or spouted beaker)? | | | | | |  |  |
| Do you have a special diet (e.g., pureed, soft, vegetarian, low fat, halal, gluten free)? | | | | | |  |  |
| Do you use thickening agents in drinks/fluids? | | | | | |  |  |
| Do you have a PEG/Gastrostomy Tube? | | | | | |  |  |
| Are you prescribed any Food Supplements? | | | | | |  |  |
| Is the Dietician or SALT (Speech and Language Therapist) involved in your care? | | | | | |  |  |
| Do you require any prompting/supervising or support to eating your meals? | | | | | |  |  |
| Do you have any history of choking episodes? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Weight | Height | | | BMI | | | |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Elimination Needs Assessment | | | | | | Yes | No |
| Do you require any support to meet your continence needs? | | | | | |  |  |
| Do you need any assistance to get to and from the toilet? | | | | | |  |  |
| Do you have any special equipment in relation to continence needs (e.g., commode, stoma, urinal bottle, incontinence wear, catheter, convene)? | | | | | |  |  |
| Do you take any medication to help your bowels or bladder? | | | | | |  |  |
| Are you prone to Urinary Tract Infections, constipation or diarrhoea? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Mobility Needs Assessment | | | | | | Yes | No |
| Do you need support to stand, transfer or walk? | | | | | |  |  |
| Do you need any support to reposition when in bed or chair? | | | | | |  |  |
| Do you require any equipment to support with mobility (e.g., wheelchair, Zimmer frame, hoist, grab aids, recliner chair, bed rails)? | | | | | |  |  |
| Do you have any history of falling or is there any concern that you may fall? | | | | | |  |  |
| Do you have any problems with your feet or legs that affect mobility (e.g., ankle swelling/oedema/bunions/blisters etc)? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Personal Hygiene Needs Assessment | | | | | | Yes | No |
| Do you need any support with bathing and showering? | | | | | |  |  |
| Do you need any support with dressing/undressing? | | | | | |  |  |
| Do you need any support with hair care? | | | | | |  |  |
| Do you need any support with foot care? | | | | | |  |  |
| Do you need any support with shaving? | | | | | |  |  |
| Do you need any support with dental hygiene/mouth care? | | | | | |  |  |
| Do you need any support with nail care? | | | | | |  |  |
| Do you currently use any aids in the bathroom (e.g., handrail or shower chair)? | | | | | |  |  |
| Do you need any support organising/attending appointments (e.g., Dentist/hairdressers etc)? | | | | | |  |  |
| Do you have a preference to the gender of your care worker? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Skin Care Needs Assessment | | | | | | Yes | No |
| Do you need any support to manage your skin care? | | | | | |  |  |
| Do you have any current bruises, wounds, skin conditions or sore areas? | | | | | |  |  |
| Are you prone to skin tears or bruising? | | | | | |  |  |
| Do you use any specialist equipment (e.g., pressure relieving mattress or cushion)? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| [Company Name] Body Map Completed (if no, must be completed at earliest opportunity) | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Medication Needs Assessment | | | | | | Yes | No |
| Do you require any assistance with taking your medication? | | | | | |  |  |
| Do you take any medication that needs specialist monitoring (e.g., Insulin, Warfarin, Digoxin)? | | | | | |  |  |
| Does anyone else support you with medication (e.g. specialist input)? | | | | | |  |  |
| Does your medication cause any side-effects that we need to be aware of? | | | | | |  |  |
| Do you have any sensitivities or allergies to any medication? | | | | | |  |  |
| Do you use any topical prescribed medication, such as creams, gels or medicated shampoos? | | | | | |  |  |
| Do you use any patches, inhalers or sublingual sprays? | | | | | |  |  |
| Do you take any non-prescribed medications or herbal remedies? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Pain Needs Assessment | | | | | | Yes | No |
| Do you have any chronic pain that is under the care of a specialist? | | | | | |  |  |
| Do you have any difficulty in telling people that you are in pain and where it is located? | | | | | |  |  |
| Do you take any prescribed/unprescribed pain relief medication on a regular basis? | | | | | |  |  |
| Do you use any non-medical aids for pain relief such as TENS Machine or hot water bottle? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Capacity/Orientation/Memory and Cognition Needs Assessment | | | | | | Yes | No |
| Do you need support to express your views, wishes, choices and preferences? | | | | | |  |  |
| Do you ever experience episodes of confusion or memory loss? | | | | | |  |  |
| Do you have any behavioural needs? | | | | | |  |  |
| Do you need any support with handling finances, voting or post? | | | | | |  |  |
| Do you need any support to access health care services (e.g. hospital appointments)? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Sleep Needs Assessment | | | | | | Yes | No |
| Do you need any support to prepare for bed (e.g., putting on nightwear, closing curtains)? | | | | | |  |  |
| Do you ever take night sedation? | | | | | |  |  |
| Do you need any support during the night with repositioning? | | | | | |  |  |
| Do you need any support to manage continence needs during the night? | | | | | |  |  |
| Do you have any problems sleeping? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| End of Life Needs Assessment | | | | | | Yes | No |
| Have you thought about where you would prefer to die (e.g., Hospice/home)? | | | | | |  |  |
| Do you have a funeral plan? | | | | | |  |  |
| Is there anyone that we would need to inform in the event of your death? | | | | | |  |  |
| Do you have any religious or cultural wishes to consider with regards to dying? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |
| Social/Religion/Cultural Needs Assessment | | | | | | Yes | No |
| Do you require any support with carrying out activities or hobbies? | | | | | |  |  |
| Do you need any support to facilitate attending external groups/places of worship or meeting friends? | | | | | |  |  |
| [Company Name] Care Plan required | | | | | |  |  |
| Abilities, Preferences, personal goals and any other details | | | | | | | |

**Care Plans**

**Following Initial Needs Assessment, select the care plans that are required:**

|  |  |  |
| --- | --- | --- |
| ✓Tick if required | Care Plan | Date Written |
|  | Rights, Capacity, Consent |  |
|  | Communication |  |
|  | Nutrition and Hydration |  |
|  | Elimination |  |
|  | Mobility |  |
|  | Personal Hygiene |  |
|  | Skin |  |
|  | Medication |  |
|  | Pain |  |
|  | Sleep |  |
|  | End of Life |  |
|  | Positive Behaviour Support |  |
|  | Activities, Hobbies and Social Support |  |
|  | Wellbeing |  |
|  | Cognition |  |
|  | Other (Please state) |  |
|  | Other (Please state) |  |
|  | Other (Please state) |  |
|  | Other (Please state) |  |
|  | Other (Please state) |  |

# Appendix 2: Care Plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Care Plan** | | **Need** |  |
| **Client’s Name** |  | **Date of Birth** |  |
| **Assessed Needs** | | **Expected Outcome (s)** | |
|  | |  | |  |
| **What does a good day look like?** | | **What does a not so good day look like?** | |
|  | |  | |
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| --- |
| **Care Plan (detail all support required)** |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Associated documents in place:** | | | | | |
|  | | | | | |
| **Who was involved in producing my Care Plan** | | | | | |
| **Name:** | | **Role /Relationship to Client** | **Signature:** | **Date:** | |
|  | |  |  |  | |
|  | |  |  |  | |
|  | |  |  |  | |
| **Does the client consent to this Care Plan? Yes/No**  **Does the client consent to sharing a copy of this care plan with the people involved in producing it? Yes/No**  **If the client does not have capacity to consent, detail who else was involved in producing this care plan in box above (e.g., Lasting Power of Attorney)** | | | | | |
| **Care Plan review**  (Care Plan to be reviewed monthly or more frequently as care needs change) | | | | | |
| **Date** | **Outcomes, concerns or changes** | | | | **Signature, Print Name and Job Title** |
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